

Facility Name & ID Number WESTMONT CONV CENTER

0030015 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>107</u>	Intermediate (ICF)	<u>107</u>	<u>39,055</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>215</u>	TOTALS	<u>215</u>	<u>78,475</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,653</u>	<u>5,639</u>	<u>7,953</u>	<u>22,245</u>	8
9	SNF/PED					9
10	ICF	<u>37,887</u>	<u>10,999</u>	<u>41</u>	<u>48,927</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,540</u>	<u>16,638</u>	<u>7,994</u>	<u>71,172</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.69%

D. How many bed-hold days during this year were paid by Public Aid?
174 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/85 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 43 and days of care provided 6,503

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **WESTMONT CONV CENTER** # **0030015** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	274,767	21,691	6,217	302,675		302,675		302,675			1
2	Food Purchase		257,335		257,335		257,335	(956)	256,379			2
3	Housekeeping	268,998	42,300		311,298		311,298		311,298			3
4	Laundry	137,818	22,292	6,278	166,388		166,388		166,388			4
5	Heat and Other Utilities			208,394	208,394		208,394		208,394			5
6	Maintenance	62,788	34,262	31,455	128,505		128,505	1,049	129,554			6
7	Other (specify):*			18,056	18,056		18,056		18,056			7
8	TOTAL General Services	744,371	377,880	270,400	1,392,651		1,392,651	93	1,392,744			8
	B. Health Care and Programs											
9	Medical Director			41,100	41,100		41,100		41,100			9
10	Nursing and Medical Records	2,320,935	134,856	299,624	2,755,415		2,755,415		2,755,415			10
10a	Therapy	133,801	797	5,140	139,738		139,738		139,738			10a
11	Activities	144,713	1,398		146,111		146,111		146,111			11
12	Social Services	79,238		1,210	80,448		80,448		80,448			12
13	Nurse Aide Training			4,957	4,957		4,957		4,957			13
14	Program Transportation			1,875	1,875		1,875		1,875			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,678,687	137,051	353,906	3,169,644		3,169,644		3,169,644			16
	C. General Administration											
17	Administrative	228,568		963,700	1,192,268		1,192,268		1,192,268			17
18	Directors Fees											18
19	Professional Services			41,361	41,361		41,361		41,361			19
20	Dues, Fees, Subscriptions & Promotions			43,526	43,526		43,526	(22,990)	20,536			20
21	Clerical & General Office Expenses	204,337	28,768	30,712	263,817		263,817	(8,483)	255,334			21
22	Employee Benefits & Payroll Taxes			691,257	691,257		691,257		691,257			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,674	2,674		2,674		2,674			24
25	Other Admin. Staff Transportation			1,000	1,000		1,000		1,000			25
26	Insurance-Prop.Liab.Malpractice			192,074	192,074		192,074		192,074			26
27	Other (specify):*			24,783	24,783		24,783	(24,783)				27
28	TOTAL General Administration	432,905	28,768	1,991,087	2,452,760		2,452,760	(56,256)	2,396,504			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,855,963	543,699	2,615,393	7,015,055		7,015,055	(56,163)	6,958,892			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	4,800
	REPAIRS & MAINTENANCE		1,417
			0
			6,217
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		6,278
			0
			6,278
5	HEAT & OTHER UTILITIES		
	GAS HEAT		45,813
	ELECTRICITY		86,981
	WATER		75,600
	CABLE TV - LOBBY		0
			0
			208,394
6	MAINTENANCE		
	GROUNDS MAINTENANCE		7,092
	PAINTING & DECORATING		2,188
	BUILDING REPAIRS		340
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		2,166
	ELEVATOR MAINTENANCE & REPAIR		4,568
	OUTSIDE LABOR		5,200
	EXTERMINATING SERVICE		4,923
	FIRE SERVICE		4,978
			0
			0
			0
			31,455
7	OTHER		
	SCAVENGER		17,513
	SECURITY SERVICE		543
			18,056
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	41,100
			41,100

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	280,893
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,235
	PHARMACY CONSULTANT	XVIII B 39-2	13,616
	UTILIZATION REVIEW FEES	XVIII B __-2	2,800
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	1,080
			0
			0
			299,624
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		
	OCCUPATIONAL THERAPY SERVICES		
	REHABILITATION CONSULTANT	XVIII B __-2	2,692
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,448
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			5,140
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	1,210
	SOCIAL WORKER	XVIII B 45-2	0
			0
			1,210
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	4,957
			4,957

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	1,875	1,875
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 963,700	963,700
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 11,533	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 29,828	
		0	41,361
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 20,203	
	EMPLOYEE WANT ADS	XIX F 9,186	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 7,395	
	LICENSES & PERMITS	XIX F 3,955	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 2,637	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	43,526
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	241	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	443	
	PENALTIES / OVERDRAFT CHARGES	VI 18 8,483	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	21,545	
	MESSENGER SERVICE	0	
		0	30,712

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 288,822	
	UNEMPLOYMENT COMPENSATION	XIX D 32,932	
	WORKERS COMPENSATION INSURANCE	XIX D 137,615	
	HOSPITALIZATION INSURANCE	XIX D 126,373	
	EMPLOYEE BENEFITS - OTHER	XIX D 100,200	
	EMPLOYEE PHYSICAL EXAMS	XIX D 5,315	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	691,257
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 2,674	
	TRAVEL	XIX G 0	
		0	
		0	2,674
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,000	1,000
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	192,074	192,074
27	OTHER		
	BAD DEBTS	VI 24 24,783	
		0	24,783

GRAND TOTAL COLUMN 3 OTHER 2,615,393

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			322,407	322,407		322,407	80,967	403,374			30
31	Amortization of Pre-Op. & Org.			21,201	21,201		21,201		21,201			31
32	Interest			664,111	664,111		664,111		664,111			32
33	Real Estate Taxes			83,311	83,311		83,311		83,311			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			79,764	79,764		79,764		79,764			35
36	Other (specify):*											36
37	TOTAL Ownership			1,170,794	1,170,794		1,170,794	80,967	1,251,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		210,133	264,426	474,559		474,559		474,559			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		210,133	382,139	592,272		592,272		592,272			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,855,963	753,832	4,168,326	8,778,121		8,778,121	24,804	8,802,925			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	80,967	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(956)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(8,483)	21		18
19	Entertainment		20		19
20	Contributions	(2,637)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,783)	27		24
25	Fund Raising, Advertising and Promotional	(20,203)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	1,049			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 24,804		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 24,804		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,049	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,049		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESTMONT CONV CENTER # 0030015 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.22				MGMT. FEE	\$ 481,850	17-3	1
2	DANIEL WEISS	ASST. ADM	ADMINISTRAT.	0.00	SEE ATTACHED			SALARY	48,191	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.16				MGMT. FEE	481,850	17-3	3
4	RICHARD HOLT	GEN. PARTNER	SECURITY	0.00				OUTS. LAB	5,200	6-3	4
5	NANCY GERACI	ADMINISTRATOR	ADMINISTRAT.	0.01				SALARY	124,227	17-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.01				SALARY	45,060	21-1	6
7	JANE HOLT	MDS. COMP. INPUT	COMP. INPUT	0.00				SALARY	12,000	10-1	7
8	VASCO HOLD	CLERK	IN SERV TRAIN	0.00				SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0.00	SEE ATTACHED			SALARY	16,800	21-1	9
10	CAROLYN HOLT	CLERK	CLERICAL	0.00				SALARY	8,800	21-1	10
11											11
12											12
13								TOTAL	\$ 1,249,178		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTMONT CONV CENTER # 0030015 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	KEY COMMERCIAL		X	MORTGAGE	\$84,015.00	05/01/98	\$ 10,000,000	\$ 9,027,523	05/01/23	7.2800	\$ 664,111	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$84,015.00		\$ 10,000,000	\$ 9,027,523			\$ 664,111	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 10,000,000	\$ 9,027,523			\$ 664,111	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																						
1. Real Estate Tax accrual used on 2002 report.			\$	82,000	1																																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	82,311	2																																			
3. Under or (over) accrual (line 2 minus line 1).			\$	311	3																																			
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	83,000	4																																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	83,311	7																																			
Real Estate Tax History:																																								
Real Estate Tax Bill for Calendar Year:		<table><tr><td>1998</td><td>72,625</td><td>8</td></tr><tr><td>1999</td><td>72,603</td><td>9</td></tr><tr><td>2000</td><td>75,156</td><td>10</td></tr><tr><td>2001</td><td>81,217</td><td>11</td></tr><tr><td>2002</td><td>82,311</td><td>12</td></tr></table>	1998	72,625	8	1999	72,603	9	2000	75,156	10	2001	81,217	11	2002	82,311	12	<table><tr><td></td><td colspan="2">FOR OHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2002</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>				FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
1998	72,625	8																																						
1999	72,603	9																																						
2000	75,156	10																																						
2001	81,217	11																																						
2002	82,311	12																																						
	FOR OHF USE ONLY																																							
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																																					
15	LESS REFUND FROM LINE 6	\$	15																																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																					
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL																																								
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.																																								

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WESTMONT CONV CENTER

COUNTY

DUPAGE

FACILITY IDPH LICENSE NUMBER

0030015

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	09-22-101-001	NURSING HOME	\$ 78,422.00	\$ 78,422.00
2.	09-22-101-002	NURSING HOME	\$ 3,888.98	\$ 3,888.98
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 82,310.98	\$ 82,310.98

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928

B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1995	\$ 349,103	1
2					2
3	TOTALS			\$ 349,103	3

Facility Name & ID Number WESTMONT CONV CENTER

0030015

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		\$ 4,982,301	\$ 127,751	39	\$ 127,751	\$	\$ 1,123,268	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING		1986		41,641	2,165	19	2,165		36,613	9
10	ROOF & WATER LINE		1987		31,143	989	20	1,557	568	25,683	10
11	IMPROVEMENTS		1988		44,614	1,416	31.5	1,416		21,943	11
12	IMPROVEMENTS		1989		40,935	1,299	31.5	1,299		18,777	12
13	DRIVEWAY		1989		17,137	1,142	15	1,142		13,464	13
14	IMPROVEMENTS		1990		37,367	1,186	31.5	1,186		15,960	14
15	IMPROVEMENTS		1991		45,002	1,428	31.5	1,428		17,611	15
16	IMPROVEMENTS		1992		49,649	1,577	31.5	1,577		18,042	16
17	ROOF TOP A/C UNITS		1993		9,100	289	31.5	289		3,155	17
18	IMPROVEMENTS		1993		53,243	1,366	39	1,366		14,193	18
19	IMPROVEMENTS		1994		31,230	801	39	801		7,726	19
20	FLOOR COVERING		1995		795	20	15	53	33	477	20
21	HAND RAIL		1995		2,249	58	39	58		515	21
22	FLOOR TILES		1995		5,471	140	39	140		1,208	22
23	WINDOW A/C UNITS		1995		14,146	363	39	363		3,069	23
24	ARJO TUB & ATTACHED PLUMBING		1995		12,056	309	39	309		2,640	24
25	ALARM		1995		1,337	34	39	34		288	25
26	LAUNDRY BUILDING		1995		35,000	897	39	897		7,438	26
27	ROOF		1995		5,520	142	39	142		1,177	27
28	WINDOWS		1995		9,478	243	39	243		1,995	28
29	DOOR EDGE & DOOR FRAME		1996		2,099	54	39	54		430	29
30	LAUNDRY BUILDING		1996		175,187	4,491	39	4,491		33,880	30
31	AIR COOLERS		1996		6,642	171	39	171		1,280	31
32	RACING CAGE		1996		3,987	102	39	102		769	32
33	HAND RAIL		1996		1,156	30	39	30		221	33
34	WINDOWS		1996		11,496	295	39	295		2,176	34
35	TACK ROOM		1996		2,139	55	39	55		401	35
36	NEW CONFERENCE ROOM-TILE		1997		2,938	76	39	76		478	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONV CENTER

0030015

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	\$ 1,478	\$ 38	39	\$ 38	\$	\$ 239	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		846	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		214	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		195	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1997	4,927	126	39	126		720	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		14,758	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		943	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		1,671	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		1,334	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		419	46
47	ANSUL FIRE SUPPRESSION SYSTEM INSTALL	1999	1,495	38	39	38		179	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		342	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		1,045	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		272	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		299	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		309	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		326	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		128	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		763	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		283	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	460	20	163	(297)	652	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		428	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		3,202	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		491	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		322	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		520	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	11,351	20	4,026	(7,325)	16,104	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		3,105	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		9,270	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		676	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		925	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861	58,445	20	13,543	(44,902)	40,629	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	3,494	20	1,456	(2,038)	2,912	69
70	TOTAL (lines 4 thru 69)		\$ 6,386,654	\$ 235,109		\$ 181,148	\$ (53,961)	\$ 1,479,398	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,386,654	\$ 235,109		\$ 181,148	\$ (53,961)	\$ 1,479,398	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	630	15	600	(30)	780	2
3	SHOWER ROOM	2002	30,924	1,125	27.5	1,125		1,359	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	328	27.5	328		342	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	541	27.5	541		564	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	5,848	20	2,003	(3,845)	4,006	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	1,678	20	575	(1,103)	1,150	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	213	27.5	213		213	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	519	27.5	519		519	9
10	THERAPY ROOM -FLOORING	2003	87,509	1,458	27.5	1,458		1,458	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	35	27.5	35		35	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,635,532	\$ 247,484		\$ 188,545	\$ (58,939)	\$ 1,489,824	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,069,217	\$59,332	\$213,041	\$153,709	3-10	\$1,574,830	71
72	Current Year Purchases	28,619	15,591	1,788	(13,803)	8	28,619	72
73	Fully Depreciated Assets	206,933					206,933	73
74								74
75	TOTALS	\$2,304,769	\$74,923	\$214,829	\$139,906		\$1,810,382	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	9,289,404
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	322,407
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	403,374
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	80,967
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,300,206

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 44,621 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2001 BMW	\$ #####	\$ 14,940	17
18	ADMINISTRATIVE	2001 JAGUAR	909.00	10,903	18
19	HSKP, MAINT	2001 CHEVROLET	775.00	9,300	19
20					20
21	TOTAL		\$ #####	\$ 35,143	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☒

130

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,377		1,377
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		3,580		3,580
9	TOTALS	\$	\$ 4,957	\$	\$ 4,957
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,957		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 116,246	\$		\$ 116,246	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,477			20,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			127,703			127,703	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				162,509		162,509	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	LAB/RENT/RADIOLOGY/TUBE FEED.	39-2					37,788		37,788	
13	Other (specify): MEDICAL SUPPLIES	39-2					9,836		9,836	13
14	TOTAL			\$		\$ 264,426	\$ 210,133		\$ 474,559	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,604,745	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	896,249		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	234,556		6
7	Other Prepaid Expenses	58,250		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate & Ins Escrow	76,634		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,870,434	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	1,653,231		15
16	Equipment, at Historical Cost	2,304,769		16
17	Accumulated Depreciation (book methods)	(3,910,277)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort of Def Mtg Cost	(120,041)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,513,499	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,383,933	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 192,119	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	705		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,753		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,959		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 461,536	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,027,523		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,027,523	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,489,059	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,105,126)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,383,933	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (917,720)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (917,718)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	930,592	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,118,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (187,408)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,105,126)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,521,941	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,521,941	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	160,060	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 160,060	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	17,159	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,159	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,770	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,770	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	140	28
28a	DISCOUNTS	14,092	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,232	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,728,162	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,392,651	31
32	Health Care	3,169,644	32
33	General Administration	2,452,760	33
	B. Capital Expense		
34	Ownership	1,170,794	34
	C. Ancillary Expense		
35	Special Cost Centers	474,559	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,778,121	40
41	Income before Income Taxes (line 30 minus line 40)**	950,041	41
42	Income Taxes	(19,449)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 930,592	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,841	2,081	\$ 66,285	\$ 31.85	1
2	Assistant Director of Nursing	1,841	2,081	58,431	28.08	2
3	Registered Nurses	28,785	31,816	728,194	22.89	3
4	Licensed Practical Nurses	18,569	20,038	383,290	19.13	4
5	Nurse Aides & Orderlies	90,142	93,026	904,798	9.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,198	10,157	133,801	13.17	8
9	Activity Director	4,187	4,556	63,098	13.85	9
10	Activity Assistants	9,489	9,916	81,615	8.23	10
11	Social Service Workers	4,244	4,617	79,238	17.16	11
12	Dietician					12
13	Food Service Supervisor	2,082	2,309	45,305	19.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,450	27,702	229,462	8.28	15
16	Dishwashers					16
17	Maintenance Workers	4,436	4,877	62,788	12.87	17
18	Housekeepers	37,383	38,930	268,998	6.91	18
19	Laundry	18,692	19,480	137,818	7.07	19
20	Administrator	1,882	2,082	124,227	59.67	20
21	Assistant Administrator	5,447	5,797	104,341	18.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,473	17,980	204,337	11.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,667	15,820	179,937	11.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	294,808	313,265	\$ 3,855,963 *	\$ 12.31	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 4,800	1-3	35
36	Medical Director	monthly fee	41,100	9-3	36
37	Medical Records Consultant	25	1,235	10-3	37
38	Nurse Consultant	monthly fee	1,080	10-3	38
39	Pharmacist Consultant	monthly fee	13,616	10-3	39
40	Physical Therapy Consultant	48	2,448	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	24	1,210	12-3	45
46	Other(specify)				46
47	Rehab Consultant	49	2,692	10a-3	47
48	Utilization Review Fees	monthly fee	2,692	10a-3	48
49	TOTAL (lines 35 - 48)	242	\$ 70,873		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,732	\$ 114,894	10-3	50
51	Licensed Practical Nurses	1,053	28,075	10-3	51
52	Nurse Aides	10,619	137,924	10-3	52
53	TOTAL (lines 50 - 52)	15,404	\$ 280,893		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	7/99	\$ 9,577	3YR	\$ 3,192	\$ 3,192	\$ 1,597	\$	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	7/00	7,646	3YR	1,274	2,549	2,549	1,274					
3	PAINTING/DECORATING	7/01	2,495	3YR		416	832	832	415				
4	PAINTING/DECORATING	7/02	2,297	3YR			383	766	766	382			
5	PAINTING/DECORATING	7/03	2,188	3 YR				365	729	729	365		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 24,203		\$ 4,466	\$ 6,157	\$ 5,361	\$ 3,237	\$ 1,910	\$ 1,111	\$ 365	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$7290
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,134 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, #0025981 09/1/85
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 117,713
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees